COOK COUNTY HEALTH & HOSPITALS SYSTEM

CCHHS

# John H. Stroger, Jr. Hospital

# Patient Safety Plan Update 2015: A Commitment to Patient Safety

Quality and Patient Safety Committee

CCHHS Board Of Directors

21 January 2015

# 2015 Patient Safety Plan

Proposed Amendments:

- ☑ Patient Safety Dashboard
- ☑ 2015 Priorities and Core Strategies

# Overview

* Introduction to Patient Safety
  * Systems vs. Person Approach
  * The Role of the Hospital Leader, Team and Clinician
* Strategies to Improve Patient Safety
* Overview and Goals of the Patient Safety Plan
  * Amended Patient Safety Dashboard
  * 2015 Priorities and Core Strategies
* Summary

# Background: Current Regulatory Environment

* National Quality Forum (NQF)
  - favors disclosure
  - endorsed Patient Safety Measures, Serious Reportable Events (see Appendix A), and Safe Practices

* The Joint Commission (TJC)
  - identifies annual Hospital National Patient Safety Goals (NPSG; see Appendix B)
  - favors reporting of Sentinel Events (see Appendix C)
  - established The Patient Safety Systems Chapter (January 2015)

* State of Illinois – law requiring reporting, not currently enforced

* Leapfrog Group – recommends reporting and disclosure

* CMS reports data publicly on Hospital Compare

# Causes of Adverse Events

* The System
* The People

# Most problems are found in processes, not in people.

# Human Factors:

**"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."**

Dr. Lucian Leape

Testimony before Congress on Health Care Quality Improvement

# Evolve from the 'people' approach to the 'systems' view

## The 'People' Approach:

* Who did it?
* Focus on an individual
* Reactive
* No communication
* Silence about events

**"You're a good employee, Humpty, but you need to learn to listen. I said, 'Don't fall.'"**

# Evolve from the 'people' approach to the 'systems' view

"Here Humpty! Put on this helmet."

**The 'Systems' View:**

* What happened?
* Focus on the system
* Proactive
* Open communication
* Honest Disclosure

# ‘Blame free’ culture versus ‘Just culture’

*Just Culture is about creating a reporting environment where staff can raise their hand when they have seen a risk or made a mistake… where risks are openly discussed between managers and staff.*

# Hospital Leaders Create Safety

* Promote learning.
* Motivate staff to uphold a fair and just safety culture.
* Provide a transparent environment in which quality measures and patient harms are freely shared with staff.
* Model professional behavior.
* Remove intimidating behavior that might prevent safe behaviors.
* Provide the resources and training necessary to take on improvement initiatives.

# Teams Create Safety

* Communicating the protocol or plan being used.
* Acknowledgement of messages and communications by those who receive them.
* Being ready to step in to support and assist team members.
* Speaking up when a patient is at risk.

# Clinicians Create Safety

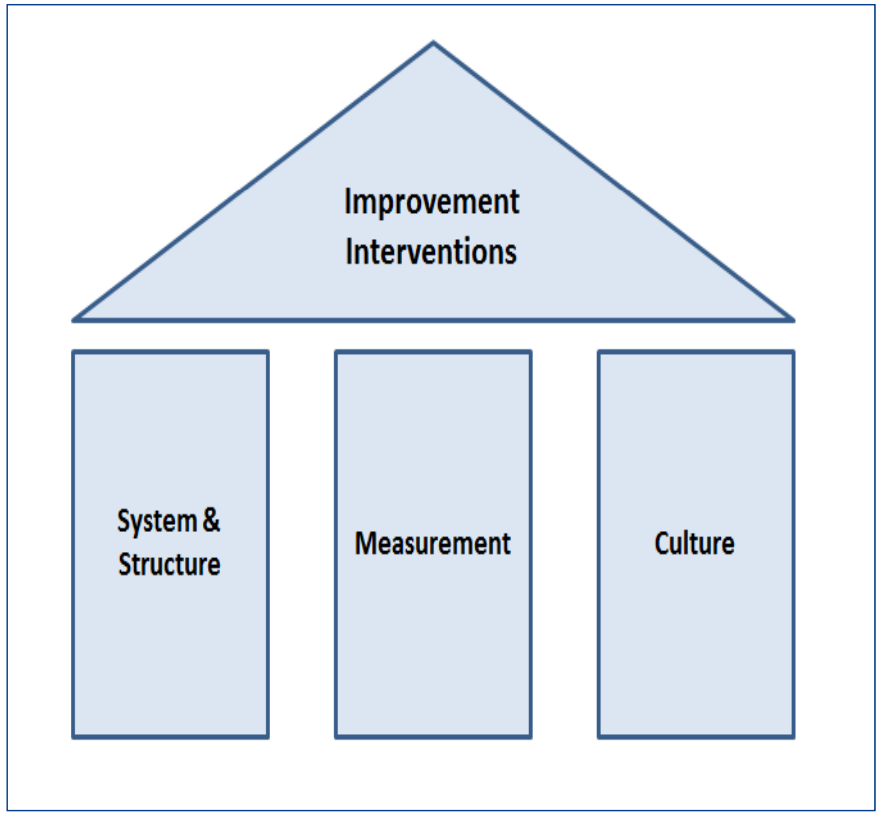
* Erring on the side of safety – speaking up and asking questions. **Being safe first and heroic afterwards.**
* Having enough humility to recognize when you are out of your depth. Be willing to ask for help and receive help.
* Reporting adverse events as well as good catches.

# Strategies to Improve Patient Safety

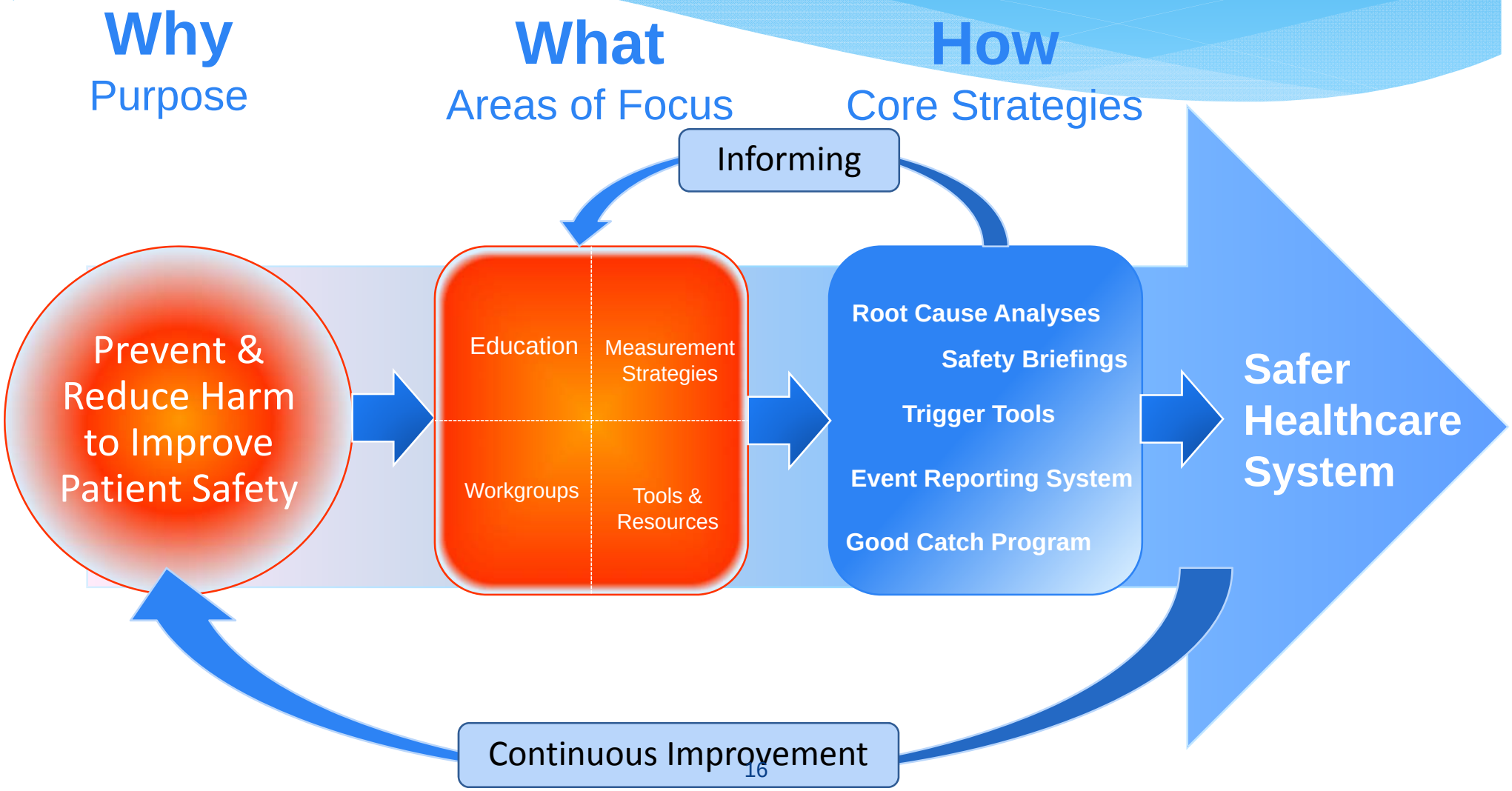
# The Patient Safety Plan

The purpose of the patient safety plan is to create a foundation, aligned with the Quality Assessment and Performance Improvement Plan (Quality Plan), for improving patient safety through:

* A standardized method to categorizing events and also classifying events based on level of harm,
* The implementation of advanced measurement tools for identifying adverse events,
* Proactive approaches to reduce harm and adverse events, and
* A governance structure that elevates communication throughout the organization and ensures accountability for the established patient safety priorities.



# John H. Stroger, Jr. Hospital Strategic Direction



# Overview and Goals of the Patient Safety Plan

| OBJECTIVE: | GOAL: | 2014 | Q1 - Q2 2015 | Q3 – Q4 2015 |
|---|---|---|---|---|
| | | ACTION PLAN TIMELINE: | | |
| **1. Create Systems** that anticipate errors & either prevent or catch them before they cause harm. | a. Enhance retrospective chart review process.<br>b. Establish an automated surveillance process.<br>c. Conduct a proactive risk assessment in a high risk area. | • Completed an in-depth analysis of risk point utilizing the methods of FMEA. | • Implement Trigger Tools.<br>• Develop automated surveillance reports in Cerner.<br>• Develop proactive plan to improve the accuracy of patient identification (NPSG.01.01.01) and improve the safety of clinical alarm systems (NPSG.06.01.01). | |
| **2. Establish Structures** for reporting and a process for managing reports in the event reporting system. | a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.<br>b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.<br>c. Establish a process for providing feedback regarding reported events. | • Implemented eMERS & PSO with UHC.<br>• Created process for reviewing & closing reports in eMERS.<br>• Created process for communicating outcome of reported eMERS events. | • Increase number of events reported by 10%.<br>• Create process for communicating root cause analysis findings and action plans. | |
| **3. Develop a Culture of Safety** where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety. | a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.<br>b. Establish a recognition program that rewards safe practices.<br>c. Improve overall perceptions of safety as measured by the Culture of Safety Survey. | • Educate Medical Staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.<br>• Develop 'Great Catch' awards program. | | • Include patient safety presentation in monthly New Employee orientation.<br>• Re-evaluate culture of safety and develop action plan.<br>• Implement Safety Briefings to encourage and reward reporting of safety problems and concerns, increase awareness of patient safety issues, and create an environment in which safety issues are shared and integrated into daily work. |
| **4. Establish Safety Priorities & Targets.** | a. Develop Patient Safety Dashboard that includes national measures and benchmarks.<br>b. Facilitate the development of action plans associated with measures not meeting benchmarks.<br>c. Assess and improve processes related to hand-off, transition & communication. | • Completed 2014 Leapfrog Safety Survey.<br>• Developed method to track & report departmental progress and compliance of RCA action plans. | • Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee and quarterly to Hospital Quality Improvement and Patient Safety Committee.<br>• Establish & implement a plan to improve performance of each leap within the Leapfrog Safety Survey. | |
| **5. Charter Safety Programs** through teams, workgroups or projects. | a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.<br>b. Reduce and eliminate variation in care. | • Established Patient Safety Council.<br>• Established workgroup to reduce patient falls & hospital-acquired pressure ulcers. | • Establish workgroups focused on medication safety and hospital-acquired infections.<br>• Revise or develop policies, procedures and protocols focused on behavioral management (e.g. AMA/elopements, restraints, chain of custody) and radiation safety. | |

# Patient Safety Dashboard

| PERFORMANCE MEASURES | IOM* Improvement Aim | DOMAIN¥ | Target | DATA SOURCE | MEASURE STEWARD |
|---|---|---|---|---|---|
| **John H. Stroger, Jr. Hospital** | | | | | |
| ***Hospital Acquired Conditions (HACs)*** | | | | | |
| **Pressure Ulcer Stages III & IV** | Safe | O | TBD | Cerner, Administrative Reports | AHRQ* |
| **Falls with Injury (per 1,000 patient days)**<br>Note: As of July 1, 2014, number of Falls includes Med-Surg and ICU/CCU Units only. Prior data included all patient falls. | | O | 0.8 | | The Joint Commission* |
| ***Hospital Acquired Infections (HAIs)*** | | | | | |
| **Central Line Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR)** | Safe | O | SIR = 0.32 | Cerner, Administrative Reports | CMS, CDC, NHSN* |
| **Catheter Associated Urinary Tract Infection (CAUTI) SIR** | | O | SIR = 0.77 | | |
| **Surgical Site Infections (SSI) SIR** | | O | SIR = 0.51 | | |
| **Ventilator Associated Events (VAE)/Ventilator Associated Pneumonia (VAP) Rate** | | O | TBD | | |
| ***Medication Safety*** | | | | | |
| ***Number of Medication Errors*** | Safe | O | TBD | eMERS | Institute for Healthcare Improvement* |
| **Medication Events with Injury per 100 Admissions** | | O | | eMERS | |
| ***Reported Events*** | | | | | |
| ***Serious Reportable Events (days since)*** | Safe | O | TBD | eMERS | Institute for Healthcare Improvement |
| ***Adverse events per 100 admissions*** | | O | | | |
| **# of Serious Reportable Events** | | O | | | |
| SURGICAL OR INVASIVE PROCEDURE EVENTS (1A - 1E) | | O | | | |
| PRODUCT OR DEVICE EVENTS (2A - 2C) | | O | | | |
| PATIENT PROTECTION EVENTS (3A - 3C) | | O | | | |
| CARE MANAGEMENT EVENTS (4A - 4I) | | O | | | |
| ENVIRONMENTAL EVENTS (5A - 5D) | | O | | | |
| RADIOLOGIC EVENTS (6A) | | O | | | |
| POTENTIAL CRIMINAL EVENTS (7A - 7D) | | O | | | |
| **# of Patients Affected** | | O | | | |
| **# of Root Cause Analyses Conducted** | | O | | | |
| **# of Events that are assocated with NPSG*** | | O | | | |
| ***Harm events ( ≥ Harm Score of 6 or Category E)*** | | | | | |
| Category E: Error that may have contributed to or resulted in temporary harm to patient & required intervention | Safe | O | TBD | eMERS | National Coordinating Council for MERP* |
| Category F: Error that may have contributed to or resulted in temporary harm to patient & required initial or prolonged hospitalization | | O | | | |
| Category G: Error that may have contributed to or resulted in permanent patient harm | | O | | | |
| Category H: Error that required intervention necessary to sustain life | | O | | | |
| Category I: Error occurred that contributed to or resulted in the patient's death | | O | | | |
| ***Litigation Statistics*** | | | | | |
| **# of cases in litigation (by date of care)** | Not Applicable | O | Not Applicable | Internal | Internal |
| **Open Cases** | | | | | |
| **Closed Cases** | | | | | |
| **Award Amounts** | | O | | | |

***Note:*** Serious Reportable Events (SREs) are also known as sentinel events and are defined by the National Quality Forum (http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx).

***LEGEND***

¥ Domain: S = Structure, P = Process, O = Outcome

* IOM: Institute of Medicine
AHRQ: Agency for Healthcare Research & Quality
NQF: National Quality Forum
TJC: The Joint Commission
CMS: Centers for Medicare & Medicaid Services
CDC: Centers for Disease Control
NHSN: National Healthcare Safety Network
IHI: Institute for Healthcare Improvement
MERP: Medication Error Reporting and Prevention

IOM Improvement Aims:
Safe, Effective, Patient-Centered, Timely, Efficient and Equitable

# 2015 Patient Safety Priorities

| Prioritization Matrix | Origin of Safety Priority | | | | SCORE |
|---|---|---|---|---|---|
| | Organizational Priority | TJC | CMS | EHEN | |
| Alarm Management | | x | | | |
| Behavioral Management (e.g. chain of custody, AMA/elopement, restraints) | x | | x | | |
| Culture of Safety | x | x | | x | |
| Hospital-Acquired Conditions (i.e. Falls with Injury, HAPUs) | | | x | x | |
| Hospital-Acquired Infections | | | x | x | |
| Medication Safety | | x | | x | |
| Patient Identification | | x | | | |
| Radiation Safety | x | | | | |

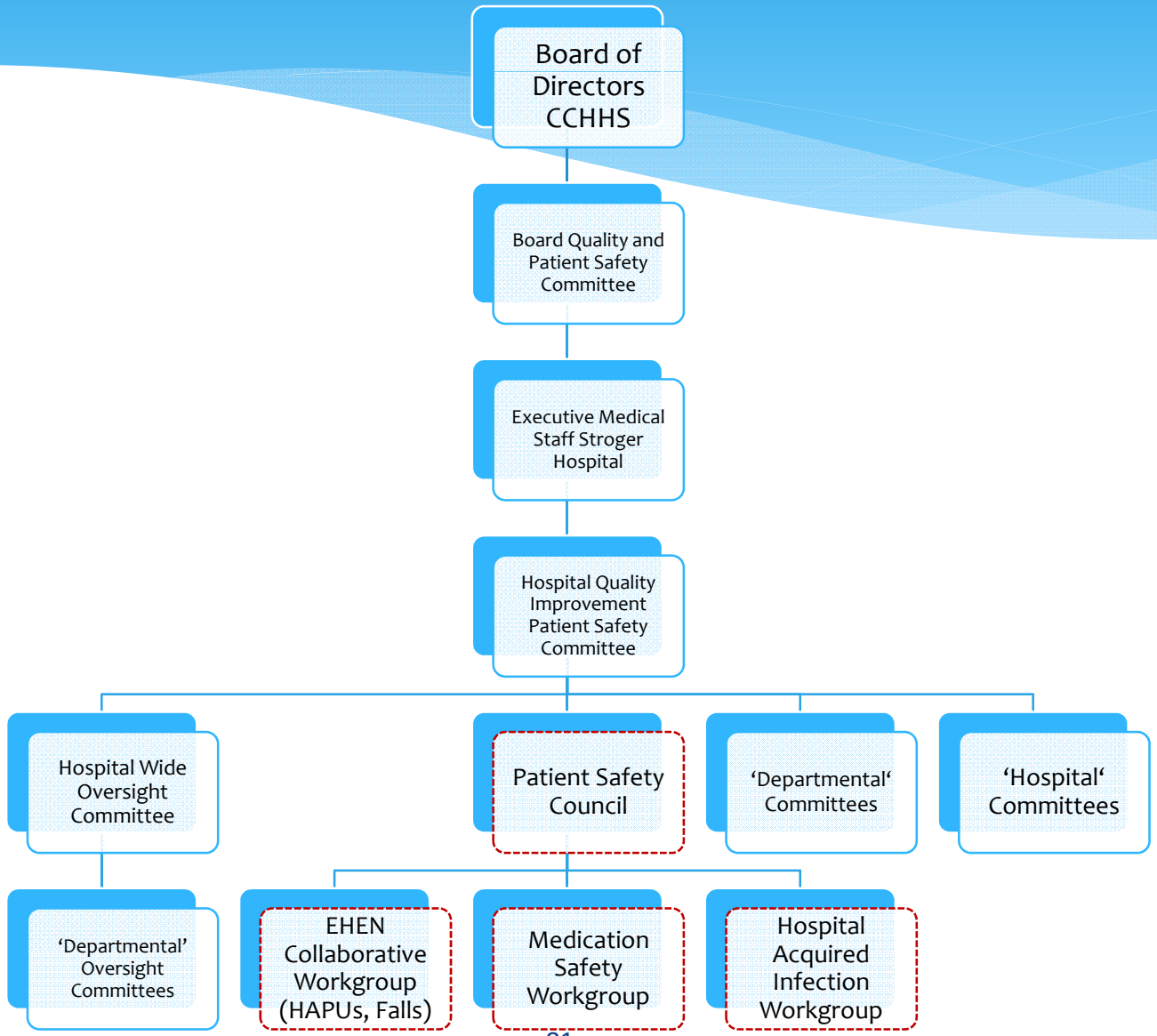
**Prioritization To Be Based On:**

- *Strategic Alignment*
- *Value*
- *Probability*
- *Visibility/Cultural Impact*
- *Feasibility*
- *Severity of Risks*



Staines, A. (2015). Prioritize: How does an organization manage a portfolio of projects. Institute for Healthcare Improvement's 26th Annual National Forum on Quality Improvement in Health Care.

# Setting a Solid and Accountable Foundation



# CORE STRATEGIES:
# Health Affairs Study on Trigger Tools (and Adverse Event Detection)

**Adverse Events In Three Study Hospitals Detected By All Methods, By Severity Level**

| Type of adverse event | Severity level | | | | | |
|---|---|---|---|---|---|---|
| | E | F | G | H | I | Total |
| Medication-related | 100 | 46 | 2 | 2 | 0 | 150 |
| Procedure-related (excluding infection) | 67 | 26 | 5 | 7 | 4 | 109 |
| Nosocomial infection | 30 | 37 | 2 | 2 | 1 | 72 |
| Pulmonary/VTE | 8 | 5 | 2 | 0 | 1 | 16 |
| Pressure ulcers | 10 | 1 | 0 | 0 | 0 | 11 |
| Device failure | 0 | 6 | 0 | 0 | 0 | 6 |
| Patient falls | 2 | 1 | 0 | 0 | 0 | 3 |
| Other | 10 | 11 | 0 | 3 | 2 | 26 |
| Total | 227 | 133 | 11 | 14 | 8 | 393 |

**Adverse Event Detection, By Severity Level And Hospital**

| | IHI Global Trigger Tool | AHRQ Patient Safety Indicators | Hospital voluntary reporting system |
|---|---|---|---|
| **SEVERITY LEVEL** | | | |
| E | 204 | 23 | 0 |
| F | 124 | 7 | 2 |
| G | 8 | 1 | 2 |
| H | 14 | 0 | 0 |
| I | 4 | 4 | 0 |
| Total | 354 | 35 | 4 |
| **HOSPITAL** | | | |
| Hospital A | 161 | 13 | 0 |
| Hospital B | 92 | 13 | 3 |
| Hospital C | 101 | 9 | 1 |
| Total | 354 | 35 | 4 |

Classen DC, Resar R, Griffin F et al, (2011). 'Global Trigger Tool' Shows That Adverse Events in Hospitals May Be Ten Times Greater Than Previously Measured. Health Affairs, 30(4), 581-589.

# CORE STRATEGIES: Weekly Safety Briefings

**Goals:**

* Encourage and reward reporting of safety problems and concerns.
* Increase awareness of patient safety issues.
* Create an environment in which safety issues are shared and integrated into daily work.

**Critical Elements:**

* Non-punitive.
* Brief meeting (30 mins.) that occurs during regular work hours.

# CORE STRATEGIES: "Good Catch" Program

* A patient safety initiative to encourage the identification of potential system errors or problems before they reach the patient and/or cause harm.
* The program will recognize staff for identifying "good catches" and will be designed to share key findings across the organization.

***GOALS:***

- Strengthen the culture of safety
- Allow staff to be recognized for their contributions
- Create a learning culture through a non-punitive environment

# Summary

* Patient safety is everyone's responsibility.
* Understanding the problem is the first step towards improvement.
* When errors are viewed as an opportunity for improvement rather than punishment, patients will benefit.

Vincent et al, (1998).
Framework for analyzing risk and safety in clinical medicine.
BMJ, 316, 1154-7.

# Appendix: Definitions

* Patient Safety – The prevention of errors and adverse effects to patients that are associated with health care.

  (World Health Organization)

* Adverse Events – A patient safety event that resulted in harm to a patient.

  (The Joint Commission)

* Good Catch – Recognition of an event or circumstance which had the potential to cause an incident or critical incident but which did not occur due to corrective action and/or other timely intervention following recognition.

  (Lucian Leape Institute at the National Patient Safety Foundation)

* Harm – Unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalization, or that result in death.

  (Institute for Healthcare Improvement)

# Appendix A: NQF Serious Reportable Events

## Appendix A – NQF-Endorsed Serious Reportable Events in Healthcare[b]

### 1. SURGICAL EVENTS

A. Surgery performed on the wrong body part
B. Surgery performed on the wrong patient
C. Wrong surgical procedure performed on a patient
D. Unintended retention of a foreign object in a patient after surgery or other procedure
E. Intraoperative or immediately post-operative death in an ASA Class I patient

### 2. PRODUCT OR DEVICE EVENTS

A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
B. Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

### 3. PATIENT PROTECTION EVENTS

A. Infant discharged to the wrong person
B. Patient death or serious disability associated with patient elopement (disappearance)
C. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility

### 4. CARE MANAGEMENT EVENTS

A. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinimia in neonates
F. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
G. Patient death or serious disability due to spinal manipulative therapy
H. Artificial insemination with the wrong donor sperm or wrong egg



*more*

[b] See the full report for applicable care settings for each event, specifications, and additional background and reference material.

# Appendix B: TJC NPSG

## 2015 Hospital National Patient Safety Goals

**The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.**

| | |
|---|---|
| **Identify patients correctly** | |
| NPSG.01.01.01 | Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment. |
| NPSG.01.03.01 | Make sure that the correct patient gets the correct blood when they get a blood transfusion. |
| **Improve staff communication** | |
| NPSG.02.03.01 | Get important test results to the right staff person on time. |
| **Use medicines safely** | |
| NPSG.03.04.01 | Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up. |
| NPSG.03.05.01 | Take extra care with patients who take medicines to thin their blood. |
| NPSG.03.06.01 | Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor. |
| **Use alarms safely** | |
| NPSG.06.01.01 | Make improvements to ensure that alarms on medical equipment are heard and responded to |
| **Prevent infection** | |
| NPSG.07.01.01 | Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning. |
| NPSG.07.03.01 | Use proven guidelines to prevent infections that are difficult to treat. |
| NPSG.07.04.01 | Use proven guidelines to prevent infection of the blood from central lines. |
| NPSG.07.05.01 | Use proven guidelines to prevent infection after surgery. |
| NPSG.07.06.01 | Use proven guidelines to prevent infections of the urinary tract that are caused by catheters. |
| **Identify patient safety risks** | |
| NPSG.15.01.01 | Find out which patients are most likely to try to commit suicide. |
| **Prevent mistakes in surgery** | |
| UP.01.01.01 | Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body. |
| UP.01.02.01 | Mark the correct place on the patient's body where the surgery is to be done. |
| UP.01.03.01 | Pause before the surgery to make sure that a mistake is not being made. |

# Appendix C: TJC Sentinel Events

## Definition of Sentinel Event

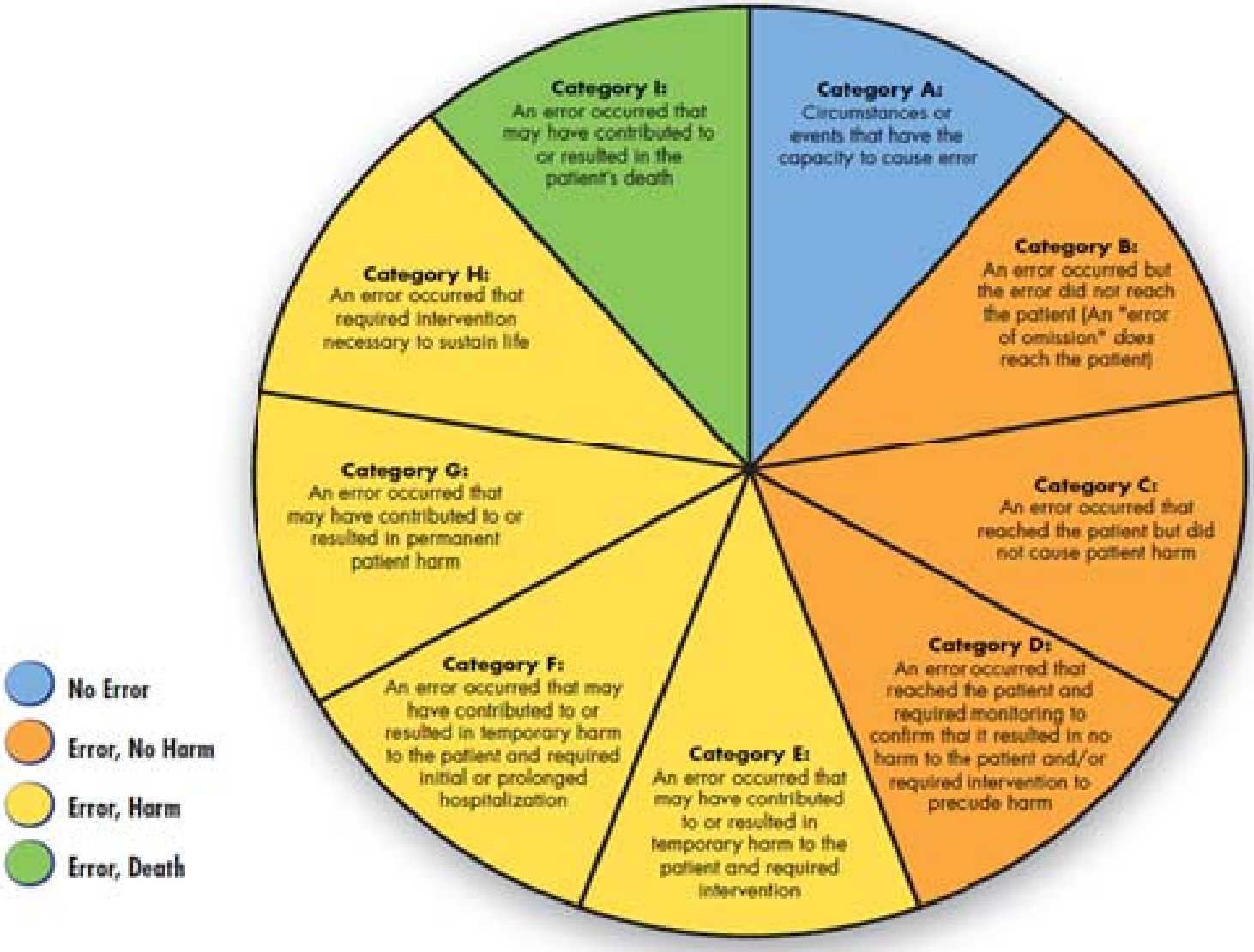
A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm*

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital†
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure‡
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery§
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care‖
- Any intrapartum (related to the birth process) maternal death or severe maternal morbidity#

# Appendix D: Categorization of Harm Level

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